State Legislative Status Report
2007-2008 Regular Session

Note: Information below is reflective of that available as of 09/15/2008.
Italic text in the summaries indicates an addition and
~~strikeout~~ indicates a deletion to the bill since the last Board meeting.

ASSEMBLY BILLS

AB 2 (Dymally) Health care coverage.
Version: Amended 08/21/2008
Sponsor: Author
Status: 09/11/2008-Enrolled.

Note: MRMIB support.
See summary on handout for Agenda Item 6(b)(1).

AB 16 (Hernandez) Human papillomavirus vaccination.
Version: Amended 05/21/2008
Sponsor: Author
Status: 08/07/2008-Enrolled.

The previous version of this bill concerned students' immunizations. This bill now changes the authority for making referrals for annual cervical cancer screening to a licensed health care practitioner. Current law gives authority to "the patient's physician, surgeon, nurse practitioner or certified nurse midwife." The bill also requires that individual and group health policies which cover cervical cancer treatment or surgery, issued on or after January 1, 2009, also cover a vaccination for human pappillomavirus.

AB 368 (Carter) Hearing aids.
Version: Introduced 02/14/2007
Sponsor: Author
Status: 08/12/2008-Enrolled.

This bill would require health care service plans and health insurers to offer or provide coverage up to $1,000 for hearing aids to all enrollees, subscribers, and the insured less than 18 years of age. The bill would provide that the requirement would not apply to certain types of insurance.

AB 1945 (De La Torre) Health care coverage.
Version: Amended 08/30/2008
Sponsor: California Medical Association
Status: 09/11/2008-Enrolled.

This bill would require health plans and insurers to obtain prior approval of the Department of Managed Health Care (DMHC) Director and the California Department of Insurance (CDI) Commissioner respectively before rescinding any health coverage. It would require the DMHC Director and CDI Commissioner to jointly establish an *independent* process for reviewing health plans' and insurers' requests to rescind an enrollee's coverage. It would allow DMHC or CDI to

approve a rescission only if the health plan or insurer demonstrates that the enrollee "made a *material misrepresentation or material omission"* ~~willful and material misrepresentation~~ about his or her medical history in the application process. The bill would also permit each regulator to assess other administrative penalties and suspend or revoke a plan's license or insurer's business certificate if they rescind coverage without prior DMHC or CDI approval. ~~It would require DMHC and CDI to assess a $50,000 administrative penalty on a health plan or insurer when a request for rescission "does not have a substantial probability of receiving final approval."~~ It would also require DMHC and CDI to establish a pool of approved questions for use on individual coverage applications by health plans and insurers that elect to sell individual coverage.

AB 2569 (De Leon) Health care coverage: rescission.
Last Amend: 08/21/2008
Sponsor: Author
Location: 09/11/2008-Enrolled.

This bill would require all health plans and insurers to *offer* ~~allow~~ *coverage to* persons *whose individuals coverage was rescinded* ~~covered under rescinded~~ ~~individual coverage to transfer~~, and to do so without medical underwriting, to any other individual policy offered by that plan or insurer *that provides equal benefits*, and to inform enrollees of this new right, at minimum when rescinding an enrollee's coverage. ~~It would require plans and insurers to notify enrollees 30 days before changing their premium rate, and require plans and insurers to post a ranking of individual coverage products on their website and notify purchasers of this information or make it available upon request.~~ The bill would also require persons assisting applicants with their health insurance application to attest in writing that the application is accurate and complete, that he or she explained to the applicant the risk of providing inaccurate information and that the applicant understood the application.

AB 2589 (Solorio) Health care coverage: public agencies.
Version: Amended 08/06/2008
Sponsor: Santa Ana School District
Status: 08/13/2008-Enrolled.

This bill would require health plans or health insurers to report annually to governing boards of public entities with which they contract the name and address of any agent, broker, or individual to whom they paid a commission or fee related to the public entity's contract or policy or involved in transactions with the public agency and the amount paid.

SENATE BILLS

SB 697 (Yee) Health care coverage: provider charges.
Version: Amended 07/14/2008
Sponsor: Author
Status: 08/11/2008-Enrolled.

This bill would explicitly prohibit any health care provider who is given documentation that a person is enrolled in the Healthy Families Program or the Access for Infants and Mothers program from "balance billing" these subscribers for health care services.

SB 775 (Ridley-Thomas) Childhood lead poisoning.
Version: Amended 08/08/2008
Sponsor: Physicians For Social Responsibility, National Health Law Program
Status: 08/19/08-Enrolled.

This bill would require the Department of Public Health to make information on lead poisoning available *on its website* ~~to all health care providers that administer perinatal or prenatal care services as specified,~~ and would require providers *primarily responsible for providing prenatal care* to refer pregnant women *to relevant information on the DPH website or provide other lead prevention information to pregnant women*. It would require DPH to report to the legislature and the public on the status and effectiveness of the state's lead poisoning prevention programs and lead screening activities, the number of children screened and those determined to have elevated blood levels. It would also require the establishment of benchmarks for Healthy Families, Medi-Cal and the Child Health and Disability Prevention Program. It would require the licensed health care provider *who is a child's primary care practitioner* to conduct or refer for a blood lead test when providing services to low-income children at specified ages who are enrolled in publicly funded programs and to document the lead testing on the child's immunization record. It would also require DHCS and MRMIB to make available to DPH "all necessary information" related to the blood lead testing of participants in public health care programs.

SB 840 (Kuehl) Single-payer health care coverage.
Version: Amended 08/11/2007
Sponsor: Author
Status: 08/31/2008-Enrolled.

This bill would establish the California Healthcare System to be administered by the newly created California Healthcare Agency, under the control of a Healthcare Commissioner. The bill would make all California residents eligible for specified health care benefits under the California Healthcare System, which would, on a single-payer basis, negotiate for or set fees for health care services provided through the system and pay claims for those services. The bill would provide that a resident of the state with a household income at or below 200 percent of the federal poverty level would be eligible for the type of benefits provided under the Medi-Cal program. The bill would create several new offices to establish policy on medical issues and various other matters relating to the health care system.

SB 973 (Simitian) California Health Benefits Service Program.
Version: Amended 08/08/2008
Sponsor: American Federation of State County Municipal Employees
Status: 08/26/08-Enrolled.

This bill is essentially the same as SB 1622, which failed to meet the deadline for passage from the Senate Appropriations Committee. This bill would create the California Health Benefits Service Program (CHBSP) within the Department of Health Care Services (DHCS). The CHBSP would identify barriers and incentives to establishing joint-ventures between local initiatives, local health plans, county organized health systems (COHS) and county health authorities with the County Medical Services Program (CMSP) and would assist local health care entities to support development of the joint-ventures. The bill would also create a stakeholder committee with six members appointed by the DHCS Director, representing CSMP, health care providers, employers, and COHS, which would report findings to the Legislature by January 15, 2010 and annually thereafter. The bill would require that all joint ventures be licensed by the Department of Managed Health Care (DMHC). The DMHC would be allowed flexibility in issuing new, modified or combined licenses to local initiatives or COHS in order to contract with the MRMIB or to provide coverage in individual or group markets. The bill would require private funding be received by the state prior to implementing nearly all CHBSP activities. *Also, the bill would limit to two the number of joint ventures that the CSMP may approve until submission of its initial report to the Legislature.*

SB 981 (Perata) Health care coverage: non-contracting hospital-based physician claims.
Version: Amended 08/22/2008
Sponsor: Author
Status: 09/03/2008-Enrolled.

This bill would require health plans to pay a non-contracting emergency room physician the lesser of the physician's full charge or the newly created "interim payment standard," as defined, *less copayments and deductibles. The bill specifies that the interim payment standard for services provided to HFP enrollees would be 125 percent of the Medi-Cal fee rate*. The bill would create various payment rates and standards for non-contracted emergency room physicians and would require the Department of Managed Health Care (DMHC) to adjust the interim payment standard every 12 months. It would create the Independent Dispute Resolution Process (IDRP) to resolve payment disputes between health plans and providers and would authorize it to assess penalties on health plans that show a pattern of "willfully violating" the provisions of this bill or that "engage in practice intended to abuse" the IDRP. ~~It would also require that noncontracting emergency physicians seeking resolution from the IDRP to first use the health care plan's dispute resolution process.~~ This bill would ~~authorize~~ *require* DMHC to seek civil penalties and *would permit it* to assess administrative penalties against non-contracting emergency room physicians, health plans or their contracting risk-bearing organizations for showing a pattern of willfully violating or a practice intended to abuse the IDRP *and would additionally require that the offender be assessed an administrative penalty consisting of the greater of either $10,000 or three times the disputed amount.* This bill would become effective on July 1, 2009 and sunset on December 31, 2013.

SB 1379 (Ducheny) Fines and penalties: physician loan repayment.
Version: Introduced 08/22/2008
Sponsor: California Medical Association
Status: 08/31/08-Enrolled.

SB 1379, an urgency measure, would transfer $1 million of fines paid by health care service plans and collected by Department of Managed Health Care (DMHC) to the Steven M. Thompson Physician Corps Loan Repayment Program (STPCLRP), and $10 million to the Major Risk Medical Insurance Program (MRMIP). In the future, the DMHC would annually transfer the first $1 million in fines to the STPCLRP and any additional fines to the MRMIP, which provides publicly subsidized health insurance to "medically uninsurable" people through California's high-risk health insurance pool.

For further information, see handout for Agenda Item 6(b)(2).

~~This bill repeals existing law that requires Knox-Keene Act fines paid by health plans to be paid into the State Managed Care Fund. It would require that these fines instead be paid into the Medically Underserved Account for Physicians within the Health Professions Education Fund. This fund provides limited repayment of education loans for physicians who practice in medically underserved areas, defined in part by populations at least 50 percent of whom are uninsured or are enrollees in HFP or Medi-Cal.~~

SB 1440 (Kuehl) Health care coverage.
Version: Amended 08/14/2008
Sponsor: California Medical Association
Status: 09/03/08-Enrolled

Current law does not limit the amount of administrative expenses that health plans or health insurers may pay with money derived from sources other than subscribers. This bill would require full-service health care service plans or health insurers to spend at least 85% of the dues, fees, premiums, and other periodic payments received by the health plan or health insurer on health care benefits (referred to as the "minimum loss ratio" or MLR) beginning January 1, ~~2009~~ *2011. It would exempt health plan contracts and policies that are two-years old or less that the Department of Managed Health Care or California Department of Insurance determine are substantially different from those plans' existing contracts or policies.* The bill would define "health care benefits" for the purpose of determining administrative expenses. For the purpose of determining the cost/benefits ratio, the bill would permit a health plan or health insurer to average its total after-tax costs across all its California health care plan contracts or health insurer policies or those of its affiliated California plans or insurers, with specified exceptions allowed. The bill would require these health plans and insurers, as of June 1, ~~2009~~ *2011*, and then annually, to report to their regulator that they meet these requirements. It would additionally require them to report, as of January 1, ~~2009~~ *2011*, and then annually, to their regulator the MLR of each individual and group health plan product or health insurance policy in California, *and would require them to disclose this information when presenting a plan for examination or sale to individuals or to groups of 50 or fewer individuals*. The regulators would be required to ~~make the MLR information public and to~~ jointly adopt implementation regulations to require uniform reporting by plans and insurers. It would also allow regulators to fine or otherwise penalize health plans and insurers for failure to comply.

SB 1553 (Lowenthal) Health care service plans.
Version: Amended 08/12/2008
Sponsor: California Society of Clinical Social Work, California Association of Marriage and Family Therapists
Status: 08/22/08-Enrolled.

This bill would prohibit health plans regulated by Department of Managed Health Care from determining an approval, modification or denial of a health care provider's request for *authorization or reimbursement for mental health* services based on whether a patient's admission was voluntary or involuntary or on a patient's method of transportation to a health facility. This would apply to determinations made before, during or after the service was provided. It would also require all health plans *that provide mental health services*, except those primarily serving Medi-Cal or Healthy Families subscribers, to include information about accessing mental health services on their websites.

SB 1634 (Steinberg) Health care coverage: cleft palates.
Version: Amended 08/13/2008
Sponsor: California Society of Plastic Surgeons
Status: 08/26/2008-Enrolled.

This bill would require health plans and health insurers, on or before ~~January~~ *July* 1, 2009, to cover medically necessary orthodontic services for cleft palate procedures upon prior authorization and completion of the utilization review processes.

Managed Risk Medical Insurance Board
Bills No Longer Being Tracked Because They Failed to Meet Legislative Deadlines or Died

Note: Reflects information available as of 09/15/2008.

AB 1 (Laird) Health care coverage.
Version: Amended 09/07/2007
Sponsor: 100% Campaign; People Improving Communities through Organizing (PICO)
Status: 09/12/2007-Held at ASSEMBLY DESK.

Note: AB 1 is identical to SB 32 (Steinberg).

The bill would have:
- Expanded eligibility for Medi-Cal and the Healthy Families Program (HFP) to cover children in families with household income up to 300% FPL from the current limit of 250% FPL.
- Created the Healthy Families Buy-In Program that would be administered by the MRMIB; the bill would have made unsubsidized HFP coverage available to children whose household income exceeds 300% of the federal poverty level and who meet other specified criteria.
- Deleted specified citizenship and immigration status requirements for Medi-Cal and HFP and would have required the MRMIB to implement a process permitting applicants to self-certify income and income deductions by January 1, 2008.
- Required the MRMIB and the Department of Health Care Services to take actions to improve and coordinate the application and enrollment process for Medi-Cal and the HFP and would have developed a process to transition the enrollment of children from local children's health initiatives into Medi-Cal and HFP.
- Established the HFP to Medi-Cal Presumptive Eligibility Program, the Medi-Cal to HFP Presumptive Eligibility Program, the Med-Cal Presumptive Eligibility Program and the HFP Presumptive Eligibility Program.
- Deemed children who have a California Children's Services (CCS) eligible medical condition and who are enrolled in the HFP or the HFP Buy-In Program to be financially eligible for CCS program benefits.

AB 1554 (Jones) Health care coverage: rate approval.
Version: Amended 06/18/2008
Sponsor: Author
Status: 06/26/2008-Senate HEALTH.

This bill would have required approval by the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) of an increase in the amount of the premium, co-payment, coinsurance obligation, deductible, and other charges under individual and group policies issued by health plan or health insurers. This would not have included a Medicare supplement contract or policy or health plan contracts issued through a state program including Medi-Cal and the Healthy Families Program. It would have created the 7-member California Health Care Rate Advisory Board (CHCRAB) and would have required the DMHC and CDI to solicit comments from CHCRAB when adopting regulations related to this bill. It would have also established criteria for the DMHC and CDI to use when reviewing and approving rates paid by health plans and insurers for medical and non-medical expenses.

AB 2146 (Feuer) Health care providers: billing.
Last Amend: 07/02/2008
Status: 07/02/2008-Read second time, amended, and re-referred to Com. on APPR.
Location: 08/07/2008-Held under submission in Senate APPROPRIATIONS.

This bill would have required the Department of Health Care Services (DHCS) and MRMIB to define "hospital-acquired conditions" consistent with the CMS definition and would have prohibited all health care providers participating in public health programs from charging patients or third-party payers for these hospital-acquired conditions. It would have further required DHCS and MRMIB to develop uniform policies and practices governing payment by state public health programs for these conditions and to annually evaluate and amend them. It would have precluded providers from billing patients for treatment of hospital-acquired conditions for which plans or insurers have denied payment in conformity with these DHCS and MRMIB nonpayment policies and practices. The bill would have precluded providers from charging patients for care or services "for which payment is denied" by MRMIB or DHCS programs. It would have also precluded providers from billing uninsured patients for hospital-acquired conditions. It would have prohibited contracts between providers and plans or insurers from including policies and practices that prohibit payment for hospital-acquired conditions.

AB 2549 (Hayashi) Health care coverage: notification.
Version: Amended 06/19/2008
Sponsor: Author
Status: 08/07/2008-Held under submission in Senate APPROPRIATIONS.

This bill would have prohibited health plans and insurers from rescinding an individual health insurance policy for any reason after 18 months from the date of its issuance.

AB 2580 (Arambula) Health: immunizations.
Version: Amended 04/01/2008
Sponsor: California Immunization Coalition,
Status: 08/07/2008-Held under submission in Senate APPROPRIATIONS.

This bill would have removed existing exceptions to immunization requirements for admittance into elementary or secondary schools, child care centers, day nurseries, nursery schools, family day care homes or development centers. Current law allows disease-specific exemptions based on age. It would have also required, on or after July 1, 2009, that pupils be fully vaccinated against pertussis before admission to 7th grade in these institutions. It would have also added the American Academy of Family Physicians to the list of those organizations whose recommendations the Department of Public Health may consider when determining other diseases for which pupils must be vaccinated.

AB 2967 (Lieber) Health care cost and quality transparency.
Version: Amended 08/13/2008
Sponsor: Service Employees International Union
Status: 08/30/08-Senate INACTIVE FILE.

This bill would have sunsetted the California Health Policy and Data Advisory Commission (CHPDAC) on July 1, 2009, and created in its place the California Health Care Cost and Quality

Transparency Committee (HCCQTC) in the Health and Human Services Agency (CHHSA). The HCCQTC would have developed a plan to improve medical data collection and reporting practices. The bill would have also required the CHHSA Secretary and the Committee to implement strategies to improve health care quality and meet related requirements. The bill would have required costs for implementing this bill be paid from assessing and collecting fees from data sources and data users in accordance with a fee schedule approved by the CHHSA Secretary. The fee schedule would have been evaluated by the Office of Statewide Health Planning and Development and by the Legislature as part of the annual budget act process.

SB 32 (Steinberg) Health care coverage: children.
Version: Amended 09/07/2007
Sponsor: 100% Campaign; People Improving Communities through Organizing (PICO)
Status: 09/11/2007-Assembly FLOOR INACTIVE FILE.

Note: SB 32 is identical to AB 1 (Laird).

The bill would have:
- Expanded eligibility for Medi-Cal and the Healthy Families Program (HFP) to cover children in families with household income up to 300% FPL from the current limit of 250% FPL.
- Created the Healthy Families Buy-In Program that would be administered by the MRMIB; the bill would have made unsubsidized HFP coverage available to children whose household income exceeds 300% of the federal poverty level and who meet other specified criteria.
- Deleted specified citizenship and immigration status requirements for Medi-Cal and HFP and would have required the MRMIB to implement a process permitting applicants to self-certify income and income deductions by January 1, 2008.
- Required the MRMIB and the Department of Health Care Services to take actions to improve and coordinate the application and enrollment process for Medi-Cal and the HFP and to develop a process to transition the enrollment of children from local children's health initiatives into Medi-Cal and HFP.
- Established the HFP to Medi-Cal Presumptive Eligibility Program, the Medi-Cal to HFP Presumptive Eligibility Program, the Medi-Cal Presumptive Eligibility Program and the HFP Presumptive Eligibility Program.
- Deemed children who have a California Children's Services (CCS) eligible medical condition and who are enrolled in the HFP or the HFP Buy-In Program to be financially eligible for CCS program benefits.

SB 1522 (Steinberg) Health care coverage: coverage choice categories.
Version: Amended 08/15/2008
Sponsor: Health Access
Status: 08/07/2008-Assembly THIRD READING.

This bill would have required the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) by April 1, 2009 to jointly adopt regulations to develop systems to categorize all full-service (non-specialized) health plan contracts and health insurance policies offered and sold to individuals (non-group coverage) into 5 coverage benchmark categories. It would have required each full-service plan and insurer offering individual coverage to offer at least one contract or policy in each coverage category and meet various standards for price, benefits, type of product (HMO, PPO, EPO, POS, indemnity model,

etc.). The bill would have required that full-service plans and insurers be given flexibility in establishing provider networks for the new products as long as they meet access-to-care standards and other specified requirements. The bill included other related requirements for full-service plans and insurers regarding pricing of products and their regulation. It would have also required that all individual coverage sold on or after January 1, 2009 contain a maximum limit on out-of-pocket costs, including, but not limited to, copayments, coinsurance, and deductibles, for covered benefits. It would have required DMHC and CDI to annually report on contracts and policies offered in each category and enrollment by category and, every three years, to review and consider revising the standard benefit packages to meet the needs of consumers. It would have required DMHC and CDI to develop a notice about the range of cost and benefits to facilitate comparison shopping for individual coverage, and would have required health plans and insurers to provide the notice to consumers when marketing products or sending information about purchasing or renewing coverage. It would have required the University of California Health Benefits Review Program (UCHBRP) to report on specific data about individual coverage issues 3 months prior to the development of the new benefit levels by DMHC and CDI, and would have allowed DMHC and CDI to request additional UCHBRP reports prior to their annual and triennial reviews of benefits.

SB 1525 (Kuehl) Health care service plans: onsite medical survey.
Version: Amended 04/24/2008
Sponsor: Author
Status: 08/07/2008-Held under submission in Assembly APPROPRIATIONS.

Existing law requires the Department of Managed Health Care (DMHC) to survey health plans' procedures for obtaining health services, regulating utilization, and assuring quality of care. This bill would have added a requirement that the DMHC also review health plan procedures for making determinations of medical necessity. It would have also required plans and insurers to report to DMHC or the California Department of Insurance (CDI), and, upon request, to report to enrollees and providers the rates of initial delays, denials, or modifications of health care services or payments, and the specific rates of delay, denial or modification due to services being medically unnecessary or uncovered benefits.

SBX1 27 (Aanestad) MRMIP: health care service plans: individual health care coverage.
Version: Amended 08/19/2008
Sponsor: Author
Status: 08/19/2008-Senate HEALTH

This bill would have modified MRMIP subscriber benefits, premiums, funding, and eligibility criteria.